BEFORE THE
MEDICAL BOARD OF CALIFORNIA
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Petition for Interim Suspension Order

Against:

HOOSHANG TABIBIAN, M.D., Respondent

Agency Case No. 800-2022-092780

OAH No. 2023010336

ORDER ON PETITION FOR INTERIM SUSPENSION

On February 3, 2023, the petition of Reji Varghese (Petitioner), Deputy Director of the Medical Board of California (Board), Department of Consumer Affairs, for issuance of an Interim Suspension Order pursuant to Government Code section 11529, was heard via videoconference by Julie Cabos-Owen, Administrative Law Judge (ALJ) with the Office of Administrative Hearings (OAH). Wendy Widlus, Deputy Attorney General, represented Petitioner. Derek O'Reilly-Jones, Attorney at Law, with Bonne, Bridges, Mueller O'Keefe & Nichols, represented Hooshang Tabibian, M.D. (Respondent).

The ALJ read and considered all filed papers supporting and opposing the Petition, and the ALJ heard testimony and argument at the noticed hearing. The matter was submitted on February 3, 2023.

FACTUAL FINDINGS

1. Petitioner filed the Petition while acting in his official capacity as the Deputy Director of the Board.

2. On May 21, 1984, the Board issued Physician's and Surgeon's Certificate (certificate) Number A 40845 to Respondent. Respondent's certificate is scheduled to expire on September 30, 2023.

3. On January 26, 2017, the Superior Court of California, County of Los Angeles, issued an order restricting Respondent's practice of medicine. On August 29, 2018, an Accusation was filed against Respondent, and on October 4, 2018, a First Amended Accusation was filed. The Superior Court order, the Accusation, and the First Amended Accusation arose from Respondent's alleged aiding and abetting the unlicensed practice of medicine at a cosmetic laser treatment clinic owned by an unlicensed person. Effective December 13, 2019, the Board issued a Decision adopting a Stipulated Settlement and Disciplinary Order (resolving the First Amended Accusation), revoking Respondent's certificate, staying the revocation, and placing Respondent on probation for five years. As a condition of his probation, Respondent was required to perform 100 hours of community service within the first two years of probation.

4. On April 1, 2022, Board Inspector Rachel Asendorf was assigned to take over Respondent's case as his new Probation Inspector.

5. On May 20, 2022, Asendorf conducted a quarterly interview of Respondent at his practice location. During their discussion, she became concerned when Respondent showed signs of cognitive impairment. Respondent appeared confused and seemed to have difficulty understanding her questions. He took a very long time to answer, and he spoke very slowly.

6. When Asendorf asked Respondent if he had performed any community service as required, Respondent stated he had not. When she asked why he had not engaged in any community service yet, he stated he did not know. Respondent called over his officer manager, and she confirmed Respondent had completed his required community service hours. After speaking with the office manager, Asendorf again asked Respondent if he remembered performing community service during the prior year. Respondent could not recall performing any community service. Asendorf later reviewed Respondent's community service log provided by his office manager. According to the community service log, Respondent performed six hours of community service every Tuesday and Thursday from August 5, 2021, to October 28, 2021, for a total of 150 community service hours.

7. On June 3, 2022, Asendorf prepared and subsequently transmitted a complaint to the Board requesting initiation of a new case against Respondent. The complaint was based on Asendorf's May 20, 2022 observations and concerns about Respondent's possible cognitive impairment.

8. On June 20, 2022, Joe Fleming, a peace officer with the Department of Consumer Affairs, Division of Investigation, Health Quality Investigation Unit, was assigned to investigate the complaint.

9. In June and July 2022, Fleming sought Respondent's agreement to voluntarily submit to physical and mental examinations. On August 15, 2022, Respondent's attorney informed Fleming that Respondent would agree to a mental examination but not a physical examination.

10. On August 23, 2022, Fleming received Respondent's signed Agreement for Voluntary Mental Examination.

11. On Friday, October 14, 2022, Respondent underwent a mental examination by Alex Sahba, M.D., who is certified by the American Board of Psychiatry and Neurology. Respondent was 83 years old on the date of the examination.

12. During the examination, Dr. Sahba observed Respondent "was not oriented to current month, day of the week, or today's date. His memory appeared impaired. His sense of quantitative reasoning also appeared to be impaired. He appeared to be confused about certain details. . . . His speech was slow." (Exhibit 6, p. A23.)

13. Respondent informed Dr. Sahba he last worked on "Monday," which was "three days ago," and "today is 'Thursday, August 12.'" (Exhibit 6, p. A20.) (Respondent's statement was incorrect since it was Friday, October 14.) Respondent recalled seeing two or three patients on Monday. One was a female with an ear infection, and another was a male with constipation. Respondent recalled giving the male patient pills, but Respondent did not recall the name of the pills.

14. Respondent informed Dr. Sahba that he practices medicine at two offices, one in Maywood and the other on San Vicente Boulevard in Los Angeles. He stated he supervises two nurse practitioners at the Maywood office and one nurse practitioner at the San Vicente office.

15. Dr. Sahba asked Respondent about his community service. Respondent told Dr. Sahba he did not know why the Board had placed him on probation. He did not recall how many hours of community service he performed but stated he finished his community service "three months ago." (Exhibit 6, p. A17.)

16. Dr. Sahba conducted testing on Respondent including the Millon Clinical Multiaxial Inventory-III, the Mini Mental Status Exam (MMSE), and the Rey 15-Item Memorization Test.

17. For the MMSE, Dr. Sahba noted:

> The MMSE is a widely used test of cognitive functioning. It assesses an individual's orientation, attention, memory, language, and visual-spatial skills. It is also often used to assess effort because of the simplicity of the questions. The maximum score possible is 30. Individuals who score below a certain cut-off score may have cognitive impairments. The cut-off score suggesting mild cognitive impairment ranges from 23-26. The lower the score, the more impaired the individual.
>
> [Respondent's] score is 26 out of 30. He was not able to identify the current month, day of the week, and today's date. He was not able to repeat from memory a simple sentence.

(Exhibit 6, pp. A22-23.)

18. Dr. Sahba diagnosed Respondent with Mild Neurocognitive Disorder as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5). (The ALJ takes official notice of the DSM-5 as a generally accepted tool for diagnosing mental disorders.) Dr. Sahba noted "[T]there is evidence of a modest cognitive decline from a previous level. The cognitive domains affected seem to be complex attention, learning and memory, language, and social cognition." (Exhibit 6, p. A25.)

19. As part of his evaluation, Dr. Sahba answered questions posed regarding Respondent's condition and whether it would interfere with his ability to practice medicine safely. Specifically, Dr. Sahba noted his responses as follows:

> 1. Does the subject physician have a mental illness or condition that impacts his ability to safely engage in the practice of medicine? RESPONSE: Yes[.] [¶]
>
> 3. Is the subject physician able to practice medicine safely at this time without any restrictions or conditions? RESPONSE: No. [Respondent] is not able to practice medicine safely at this time.
>
> 4. Is the subject physician unable to safely practice medicine at this time as a result of a mental illness or condition? RESPONSE: Yes. [Respondent] is unable to practice medicine safely at this time due to a neurocognitive disorder.

> 5. Does the subject physician's continued practice of medicine pose a present danger or threat to the public health, welfare or safety? RESPONSE: Yes. It does.
>
> 6. Does the subject physician have a mental illness or condition which requires monitoring, treatment, oversight or other terms and conditions in order to practice medicine safely? RESPONSE: Yes. [Respondent] has a neurocognitive disorder.

(Exhibit 6, p. A26.)

20. On referral by his attorney, Respondent sought further evaluation. On December 22, 2022, Respondent underwent a neuropsychological evaluation by Nicholas Thaler, Ph.D.

21. Dr. Thaler conducted a clinical interview and administered Respondent eleven tests, including cognitive, intelligence, and memory tests. The tests collectively confirmed that Respondent suffers from mild cognitive impairment.

22. Regarding Respondent's general cognitive functioning, Dr. Thaler noted:

> [Respondent's score Montreal Cognitive Assessment (MoCA)] would support the presence of mild cognitive impairment. He had trouble copying a clock, missed one of the sentence repetition items, could not generate words with fluency, missed one of the abstraction items, missed all the recall items, and was not oriented to the day of the week. [¶]

> Results do support that [Respondent] manifests a degree of general cognitive decline that would support the presence of Mild Cognitive Impairment.

(Exhibit B, p. B17.)

23. Regarding Respondent's attentional system, Dr. Thaler noted, "There is some indication of mild struggles in attention and processing speed although not to a substantial degree." (Exhibit B, pp. B17-B18.) Regarding Respondent's speech and language, Dr. Thaler noted, "There is some indication of language fluency struggles even when factoring in [Respondent's English as a Second Language (ESL)] status." (*Id.* at p. B18.) (Respondent's first language is Farsi.) Dr. Thaler further noted, "Mild weaknesses in visuospatial functioning were observed, which likely reflects [Respondent's] generalized cognitive struggles." Regarding Respondent's auditory-verbal learning and memory, Dr. Thaler noted, "[Respondent] unfortunately demonstrated declines in his auditory-verbal learning and memory. This measure was normed for Farsi-speaking individuals, so ESL factors would not account for his poor performance on this measure." (*Ibid.*) Regarding Respondent's visual learning and memory, Dr. Thaler noted, "There is evidence a support that [Respondent] loses information over time. He was able to successfully recognize images on a second measure, which would indicate that he does not have a global amnestic condition." (*Ibid.*) Regarding Respondent's executive functioning, Dr. Thaler noted, "There is some indication of frontal/executive disturbance that likely reflects cognitive impairment in this patient." (*Id.* at p. B19.)

24. Like Dr. Sahba, Dr. Thaler diagnosed Respondent with Mild Cognitive Impairment. Dr. Thaler explained his diagnosis, and he noted Respondent's cognitive decline since Dr. Sahba's evaluation and likely continued decline as follows:

Results from this evaluation identified struggles in [Respondent's] general cognitive functioning with particular weaknesses on measures of memory recall. . . . It does appear that [Respondent] has signs of Mild Cognitive Impairment (MCI) at this time. Emotional and environmental factors (e.g., poor sleep, stress) would not account for the cognitive difficulties observed with this patient.

In comparing the current results to Dr. Sahba's evaluation, there does appear to be some indication of progression in cognitive loss. The patient could recall words after a delay with Dr. Sahba's MMSE, but could not recall any words on the MoCA, which was administered in Farsi. His scores on a second Farsi memory measure would support memory decay. This was similarly observed on two visual memory measures (although not severely on one of the visual memory measures). Qualitatively, [Respondent] did appear somewhat confused as to the purpose of this evaluation and attributed his ongoing investigation to a lawsuit that appears to have been resolved. He was not aware of any other allegations that would prompt the current evaluation. This pattern of amnestic memory loss and some struggles in orientation could represent a cortical degenerative process.

[Respondent] does not meet criteria for a dementia syndrome at this time, although the emergence of a Major Neurocognitive Disorder at a later time is likely. It is

> important to note that the patient has a number of neurovascular risk-factors, including hypertension, high cholesterol, and diabetes, which could support the presence of a vascular contribution to his cognitive decline. Additional diagnostic workup, including neuroimaging, would help narrow the etiology of [Respondent's] MCI. It bears mention that a diagnosis of MCI does not in of itself prevent a physician from working in a general outpatient practice. As the patient does have preservation in his [Instrumental Activities of Daily Living] and is not amnestic, he likely can continue to practice as a general practitioner for the time being. However, he does require some restrictions in place to ensure that he can practice in a safe manner.

(Exhibit B, p. B19.)

25. Dr. Thaler recommended the following restrictions to allow Respondent to practice safely:

> 1. [Respondent] should undergo a PET/MRI of his brain to help determine any intracranial and functional abnormalities that would explain his MCI.
>
> 2. If he has not already, [Respondent] should secure a primary health provider and undergo a full physical examination to further assess his health status.

3. [Respondent] should undergo peer review, now and every three months until he retires from his practice. A proportion of his charts (e.g., 20%) should be randomly pulled and reviewed.

4. [Respondent] should reduce his patient volume down to about half (i.e., 50%) of his prior practice.

5. [Respondent] should undergo a neuropsychological reevaluation in six months to track any progressive cognitive decline. The current results can serve as a baseline for any future neuropsychological testing. Depending on results in six months, he may not be safe to practice medicine at that time.

(Exhibit B, p. B19.)

26. Although Dr. Thaler opined Respondent could continue practicing as a physician for at least six months (when he would be re-evaluated to track progressive cognitive decline), Dr. Thaler did not adequately explain how the recommended restrictions would ensure Respondent could practice medicine safely despite his cognitive impairment and likely continued decline.

27. Dr. Sahba testified credibly at the hearing. He opined that Dr. Thaler's recommendations of chart review and reduced patient volume are insufficient to protect public safety. Dr. Sahba noted that periodic chart review is focused on proper recordkeeping and cannot necessarily detect whether a physician is practicing safely. Dr. Sahba also noted that, given Respondent's cognitive decline, reducing his patient volume to even one percent does not make patients safer. Dr. Sahba insisted

Respondent's patient case load should be zero because he cannot practice medicine safely.

28. The evidence established Respondent has a mental condition, i.e., Mild Neurocognitive Disorder, that impacts his ability to safely engage in the practice of medicine. Respondent is currently unable to safely practice medicine, and his continued practice of medicine would pose a present danger or threat to the public health, welfare, and safety.

29. Respondent provided letters of support from two patients and several colleagues who collectively described him as kind and dedicated physician.

LEGAL CONCLUSIONS

1. An administrative law judge may issue an interim order "suspending a license, imposing drug testing, continuing education, supervision of procedures, limitations on the authority to prescribe, furnish, administer, or dispense controlled substances, or other license restrictions." (Gov. Code, § 11529, subd. (a).)

2. "Interim orders may be issued only if the affidavits in support of the petition show that the licensee has engaged in, or is about to engage in, acts or omissions constituting a violation of the Medical Practice Act . . . or is unable to practice safely due to a mental or physical condition, and that permitting the licensee to continue to engage in the profession for which the license was issued will endanger the public health, safety, or welfare." (Gov. Code, § 11529, subd. (a).)

3. An administrative law judge "shall grant the interim order if, in the exercise of discretion, the administrative law judge concludes that: (1) There is a

reasonable probability that the petitioner will prevail in the underlying action; [and] (2) The likelihood of injury to the public in not issuing the order outweighs the likelihood of injury to the licensee in issuing the order." (Gov. Code, § 11529, subd. (e).)

4. The affidavits in support of the Petition establish that Respondent is unable to practice safely due to a mental condition and that permitting him to continue practicing medicine will endanger the public health, safety, and welfare. Both evaluators diagnosed Respondent with mild cognitive impairment. Dr. Sahba opined Respondent could not practice medicine safely, and Dr. Thaler determined Respondent could not practice medicine safely without restrictions.

5. Given the consensus regarding Respondent's mental condition and its effect on his ability to practice medicine safely, there is a reasonable probability that Petitioner will prevail in the underlying action.

6. The evidence established the likelihood of injury to the public in not issuing an interim order outweighs the likelihood of injury to the licensee in issuing an interim order.

7. The parties disagree about the nature of the interim order, i.e., whether full suspension or only practice restrictions should be ordered. Dr. Sahba opined a full suspension was necessary, while Dr. Thaler opined Respondent could practice medicine safely with restrictions. Pursuant to Government Code 11529, subdivision (a), license restrictions may be imposed, rather than full suspension. However, restrictions should be tailored to provide appropriate public protection by ensuring the physician's ability to practice medicine safely.

8. Respondent's argument that the practice restrictions recommended by Dr. Thaler would sufficiently protect the public is unpersuasive. Dr. Thaler

acknowledged Respondent's progression of cognitive loss in the two months since Dr. Sahba's evaluation. Dr. Thaler also opined that the eventual emergence of a Major Neurocognitive Disorder is likely. This places Respondent's patient population at a continually increasing risk. Reducing Respondent's patient load as Dr. Thaler suggests would address the quantity of Respondent's medical practice, not the quality. Dr. Thaler's recommendation would not eliminate the risk of patient harm but instead would limit the risk of injury to a smaller population of patients. Respondent would still pose a danger to his remaining patient population. Furthermore, periodic peer review of a percentage of Respondent's medical charts would provide insufficient oversight of the quality of Respondent's patient care as opposed to his recordkeeping ability.

9. Based on the evidence and the argument presented, the issuance of an Interim Order of Suspension is warranted at this time.

10. The Interim Order of Suspension set forth below is not based on any wrongdoing by Respondent. Rather, this suspension is an unfortunate consequence of Respondent's cognitive impairment and likely continued decline that creates an increasing risk of patient harm. The Board is not required to wait until actual patient harm occurs. (*In re Kelley* (1990) 52 Cal.3d 487, 495.) Consequently, the order below is necessitated by the Board's priority of public protection. (Bus. & Prof. Code, § 2229.)

ORDER

1. The Petition for Interim Order of Suspension is granted.

2. Physician's and Surgeon's Certificate Number A 40845, issued to Respondent, Hooshang Tabibian, M.D., is hereby suspended pending a full administrative determination of Respondent's fitness to practice medicine.

3. Respondent shall not:

a. Practice or attempt to practice any aspect of medicine in California until the final decision of the Board following an administrative hearing;

b. Be present in any location which is maintained for the purpose of practicing medicine, except as a patient;

c. Advertise, by any means, or hold himself out as practicing or available to practice medicine.

4. If an accusation is not filed and served pursuant to Government Code sections 11503 and 11505 within 30 days of February 3, 2023 – the date on which the parties to the hearing on the interim order submitted the matter – this order shall be dissolved. (Gov. Code, § 11529, subd. (f).)

DATE: 02/08/2023

Julie Cabos-Owen

JULIE CABOS-OWEN

Administrative Law Judge

Office of Administrative Hearings